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Health Care and the FTC: The Agency as Prosecutor and Policy Wonk

(Health Care as the New Cement; and Actions Against the Pharmaceutical Industry as a Game of Whack-a-Mole)

I. Introduction

It is a great pleasure to be here speaking before the antitrust health care bar. Let me start with the usual disclaimer that this speech does not necessarily reflect the views of the Commission or any other individual Commissioner.

I certainly have learned a lot on the antitrust front since joining the Commission last September. I still may be learning the ins and outs of HHIs and coordinated interaction, as well as the meaning of clinical integration and financial risk-sharing, but the importance of competition in health care for American consumers is clear to everyone, as is the absence of adequate competition in some health care markets.

Health care, appropriately, has been a primary focus of the Commission's agenda. I think it is fair to say that the Commission spends more resources ensuring competition and protecting consumers in health care markets than in any other segment of our economy. Our current Chairman, Debbie Majoras, spoke to the importance of health care competition in an address earlier this year, stating that "we serve health care consumers by battling anticompetitive restraints in health care markets and by challenging false and misleading health care claims."[1] Commissioner Pamela Jones Harbour also recently spoke concerning health care, noting that the Commission has been paying "very close attention" to this sector and citing the critical need for the Commission to continue doing so.[2] I agree with these statements and my sense is that this

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[1] Deborah Platt Majoras, Chairman, Federal Trade Commission, *The Federal Trade Commission: Fostering a Competitive Health Care Environment That Benefits Patients*, remarks before the World Congress Leadership Summit, New York, NY (February 28, 2005), at 1, *available at* www.ftc.gov/speeches/majoras/050301healthcare.pdf.

[2] Pamela Jones Harbour, Commissioner, Federal Trade Commission, *A "Check-Up" of Selected Health Care Activity at the Federal Trade Commission*, remarks before the ABA

trend – the Commission's continued focus on health care competition – will continue.

I spent some time working with the movie industry before joining the Commission last year, so in an attempt to make a weak tie in to my prior experience, let me give you some of the coming attractions for this speech – though I hope that, having seen the trailer, you'll stick around for the feature presentation. Initially, I'll discuss how the Commission is a unique agency – created by Congress not only to enforce the antitrust laws, but also to study industry practices to better understand how competition works. That is, we are both "prosecutor and policy wonk." Then I'll discuss health care as – perhaps the best example – of how the Commission utilizes these twin roles. Finally, I'll discuss a few areas the Commission should examine more closely through a combination of enforcement and policy efforts – including studying the competitive implications of authorized generics, and considering concepts such as "sweeps" to more aggressively deter physician price-fixing. I'll also discuss the serious ramifications of the 11th Circuit's decision in *Schering* – which not only undermines our efforts to block anticompetitive brand-generic patent settlements, but also turns on its head the standard for appellate review of agency decision-making.

II. Importance of FTC's Dual Roles – Prosecutor and Policy Wonk

Some might suggest that an enforcement agency can effectuate its mission without a policy component. Certainly there are agencies that operate in that manner or, while having the means to affect policy, choose not to do so. The architects of our Commission, however, chose a different model – one that utilizes both enforcement and policy tools. And those entrusted to run the Commission – at least in recent decades – have chosen to use those tools to advance the Commission's goals.

The Commission's mission, as you know, is to protect consumers against the harms of anticompetitive and fraudulent conduct. The Commission achieves this goal through vigorous enforcement of the antitrust and consumer protection laws. At the same time, we achieve our mission through careful study of the evolving business landscape, informed interaction with market participants and legislators, and diligent efforts at public education. Our policy role is core to the Commission's mission because it not only allows the Agency to affect the world without resorting to the courts, it informs when we should or should not bring cases.

In 1914, when President Woodrow Wilson was promoting the idea of a federal trade commission to Congress, he recognized the importance of the Commission's policy function. In an address before a joint session of Congress entitled "Additional Legislation for the Control of Trusts and Monopolies," he stated that the businessmen of the country "desire something more

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Antitrust Section Spring Meeting, Washington, D.C. (March 30, 2005), at 1-2, *available at* www.ftc.gov/speeches/harbour/050330healthcarecheckup.pdf.

than the menace of legal process."[3] Rather, he said, they "desire the advice, the definite guidance and information which can be supplied by an administrative body, an interstate trade commission." In this Wilsonian vision, the agency would be an "indispensable instrument of information and publicity, a clearing house for the facts by which both the public mind and the managers of great business undertakings should be guided, and as an instrumentality for doing justice to business where the processes of the courts or the natural forces of correction are inadequate."

Two years later, in 1916, one of the original FTC Commissioners, William J. Harris, noted the widespread perception, or rather, misperception, that the agency was to be solely "an inquisitorial body which would be ever searching the field of business like a detective for evil-doers."[4] Instead, Harris said, the Commission's "duty is quite as much to bring to light what is sound and serviceable in business as what is sinister; to give the Government and the public a correct knowledge of the facts of business so that the laws and their administration may promote and not, through the misunderstanding, hinder the interest of us all."

The structure of the FTC Act itself clearly sets forth these twin goals. It provides enforcement authority under Section 5 of the FTC Act, but also contains Section 6(b) power to issue subpoenas to obtain information from parties about their "conduct, practices, [and] management." Such information can be used, and has been used, as part of industry-wide studies, including the first studies done by the Commission on petroleum from 1914 to 1917, consuming ten percent of our then budget.

While President Wilson and Congress designed the agency to undertake both an enforcement and policy role, the question remains whether the Commission has acted to fulfill that vision. My sense is clearly "yes." You can see this through the workshops we hold and the reports we produce, many of which relate to the cases we bring.

When we host a workshop, we bring together some of the best and the brightest thinkers and informed industry representatives. We do so in an effort to understand the industry better; get a handle on the problems it faces; and begin the process through which we take a position on its practices.

Some recent workshops of note – and let me apologize for starting with the consumer protection side of the Commission house in speaking to an antitrust audience – include our spyware workshop, in which we analyzed a problem that threatens to undermine the promise of the Internet, and our e-mail authentication workshop, in which we discussed the imperative for

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[3] H.R. Doc. No. 625, 63d Cong., 2d Sess. 3 (1914).

[4] William J. Harris, Commissioner, Federal Trade Commission, *The Work of the Federal Trade Commission*, remarks before the American Cotton Manufacturers Association, Atlanta, GA (April 4, 1916), at 6, *available from FTC library.*

an authentication standard to aid in our fight against Spam. On the competition side, the Health Care and Intellectual Property Hearings under Chairmen Pitofsky and Muris provided comprehensive venues for discussion of these important subjects. The Intellectual Property Report[5] made recommendations which are providing a basis for Congress's consideration of patent reform.

As long as Congress continues to examine intellectual property and antitrust matters, it would be extremely useful for the Commission and the Department of Justice ("DOJ") to publish the long-awaited second Report stemming from those hearings. Let's hope that the Commission doesn't have to issue that Report on its own.

Why is it vital that we continue fully utilizing both our enforcement and policy making functions? Here's why. If we were solely an enforcement agency, we would certainly bring cases against bad conduct, but we would likely not have the policy tools to shed light on and deter anticompetitive activities. If we were merely a think tank, we might have good ideas but no teeth to effectuate them. By acting as both prosecutor and policy wonk, we add synergies and are more effective and efficient.

III. The Commission's Health Care Accomplishments Are a Prime Example of the Dual Roles at Work

Health care has been a primary focus of the Commission's agenda for decades. The Commission today continues to devote more of our prosecutorial resources toward health care than any other segment of our economy. Our Health Care Division – which is responsible for much of the work – is our largest division in the Bureau of Competition, with more than 30 professionals. In addition, two of our merger divisions spend a significant percentage of their time looking at hospital, pharmaceutical, PBM, medical device, and related health care deals; and a Task Force examined consummated hospitals mergers and evaluated the effects of such transactions. The efforts of that Task Force are most visibly seen in the Commission's decision early last year to challenge the Evanston hospital merger. That trial ended about a month ago, and we are awaiting the decision by the ALJ.

We also have devoted significant resources to health care on the policy side. The 2002-2003 Health Care Hearings and resulting 2004 Report[6] was one of the largest endeavors

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[5] FEDERAL TRADE COMM'N, TO PROMOTE INNOVATION: THE PROPER BALANCE OF COMPETITION AND PATENT LAW AND POLICY: A REPORT BY THE FEDERAL TRADE COMMISSION (October 2003) (hereinafter "Intellectual Property Report"), *available at* www.ftc.gov/os/2003/10/innovationrpt.pdf.

[6] FEDERAL TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (July 2004) (hereinafter "Health Care Report"), *available at*

undertaken by the Commission in the Muris years. One important issue touched on in the Health Care Report involves the contracting practices of group purchasing organizations ("GPOs"). GPOs use their group purchasing power – in tandem with tying, bundling, or exclusive dealing arrangements – in ways that can be efficient. But as the Report also notes, "under certain circumstances these practices may be harmful to competition" – especially under the theory espoused by the Third Circuit in *LePage's*.[7] Whether such circumstances exist regarding a specific practice by a particular GPO – a very fact intensive question – is something that the Commission should look for and pursue, if we find the appropriate case.

Yet another indication of the Commission's recognition of the importance of this area are the Health Care Guidelines, updated in 1996.[8] To be sure, guidelines aren't new: in the 1960s we issued guidelines on cement mergers – at least one iteration of which was written in part by former Commission staffer Richard Posner. Does health care rise to the level today that cement did decades ago? Yes. Health care is the new cement.

It should not be surprising that in an area as important as health care the Commission has used all of its tools to effectuate our goals. To demonstrate how well these tools work in tandem, let's focus on the Commission's experience over the past five years with pharmaceutical markets. To be sure, the pharmaceutical industry provides great benefits to American consumers on a daily basis. However, as in any market that delivers important products and innovation, drug companies – both brands and generics – sometimes take actions to advance their own pecuniary interests at the expense of consumers. Sometimes those actions run afoul of the antitrust laws.

Until the mid 1990's, the Commission had not dedicated substantial non-merger resources to the pharmaceutical industry. However, at that time, we started to see disturbing new conduct that harmed consumers by delaying or blocking generic entry. Bob Pitofsky was the Chairman then and, working with the Bureau of Competition's lawyers in our Health Care Division, we began looking at agreements between brand and generic companies that had this effect.

Those early inquires led to two major consent agreements in 2000 and 2001 in

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http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[7] *LePage's, Inc. v. 3M*, 324 F.3d 141 (3d Cir. 2003).

[8] DEP'T OF JUSTICE & FEDERAL TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996).

Abbott/Geneva[9] and *Hoechst/Andrx*.[10] These consents put the pharmaceutical industry on notice – both brand and generic firms – that we would carefully scrutinize patent settlement agreements in which money was exchanged to delay generic entry, or in which the agreement manipulated the 180-day generic exclusivity to prevent subsequent generics from getting to market. In those two consents, the Commission barred the parties from entering into similar agreements, and the Commission statement accompanying the *Abbott/Geneva* consent warned that, in the future, the Commission would consider its entire range of remedies in enforcement actions – including possibly seeking disgorgement. These actions, and our continued investigations and litigation – including the *Schering* case – demonstrated that the Commission would be vigilant in challenging conduct that harmed consumers by gaming Hatch-Waxman.

Following these consents, the Commission investigated a new variety of bad conduct – this time unilateral conduct by brand pharmaceutical companies – with the same pernicious effect of delaying generic entry. That conduct involved abuses of the regulatory process: listing patents in the FDA's Orange Book that did not belong there, resulting in not only a single automatic 30-month stay of generic competition, but additional 30-month stays as well.

Again through enforcement, the Commission shed light on these practices. In the *Biovail* consent,[11] issued in October 2002, the Commission charged Biovail with wrongfully listing a patent in the Orange Book and making misleading statements to the FDA resulting in an unwarranted 30-month stay. The consent prohibited Biovail from undertaking similar conduct in the future. Six months later in April 2003, the Commission obtained relief against *Bristol-Myers Squibb*,[12] settling charges that the company engaged in a pattern of anticompetitve conduct, including improper listings of patents on three separate drug products.

Did the Commission's enforcement actions have a deterrent effect? Of course, but the other tools in our policy arsenal – including the Commission's 2002 Generic Drug Study[13] –

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[9] *Abbott Laboratories and Geneva Pharmaceuticals, Inc.*, No. C-3945, C-3946 (consents issued on May 22, 2000) *available at* www.ftc.gov/os/2000/03/abbot.do.htm *and* www.ftc.gov/os/2000/03/genevad&o.htm.

[10] *Hoechst Marion Roussel, Inc.*, D. 9293 (consent issued May 8, 2001), *available at* www.ftc.gov/opa/2001/04/hoechst.htm.

[11] *Biovail Corporation*, C-4060 (consent order issued October 2, 2002), *available at* www.ftc.gov/opa/2002/04/biovailtiazac.htm.

[12] *Bristol-Myers Squibb Company*, C-4076 (consent order issued April 14, 2003), *available at* www.ftc.gov/opa/2003/03/bms.htm.

[13] FEDERAL TRADE COMM'N, GENERIC DRUG ENTRY PRIOR TO PATENT EXPIRATION: AN FTC STUDY (July 2004) (hereinafter "Generic Drug Study"), *available at*

bolstered our enforcement efforts. That Study analyzed how generic drug competition had evolved under Hatch-Waxman and concluded the law was susceptible to strategies to impede generic entry. It accomplished exactly what Wilson envisioned back in 1914 – "definite guidance and information . . . supplied by . . .[the C]ommission." Using our subpoena power under Section 6(b), the Study found that from 1992-2000 there were twenty settlements with the first generic applicants prior to patent expiration, and that fourteen of those settlements had the potential to delay generic entry. On Orange Book listings, the Study detailed eight instances – including six between 1998 and 2000 – where brand firms listed patents resulting in delays of generic entry of up to 40 months beyond the original 30-month stay.[14]

What happened next? Our actions drew notice from the industry, the bar, and the media. Responding to our work – FDA and Congress took action. FDA issued new rules adopting several of the Commission's recommendations. Congress then adopted many of those same recommendations in amending Hatch-Waxman itself. These changes limited brand firms to only one 30-month stay, choking off the most egregious manipulation. Congress also required that certain patent settlements between brands and generics be filed with the Commission and DOJ, giving us better means to identify anticompetitive arrangements, and augmenting the deterrent effect of the Commission's previous prosecutions.

In the area of exclusionary payments (and other anticompetitive activities by pharmaceutical companies), we achieved important results. But we did not achieve these results on our own. State Attorneys General have been quite active in this area. We have jointly investigated many cases with our colleagues in the States, and our cooperation on antitrust enforcement has benefitted consumers. DOJ's health care attorneys also have been instrumental in developing the Agencies' joint Health Care Guidelines and pursuing enforcement. Moreover, the threat of treble damages in private actions – which often follow our investigations – has been a significant deterrent to anticompetitive conduct.

Of course, in health care policy, as in any good movie, there is never a happy ending until after the protagonist endures setbacks and tribulations. In a classic reversal of fortune – for consumers – the 11th Circuit vacated the Commission decision in *Schering*, which challenged abusive patent settlements between Schering and two generic companies.[15] The 11th Circuit opinion, if allowed to stand, could foster the resumption of these anticompetitive patent

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www.ftc.gov/os/2002/07/genericdrugstudy.pdf.

[14] Generic Drug Study, at 26, 46.

[15] *In the Matter of Schering-Plough Corporation, et al.*, FTC Dkt. No. 9297 (opinion of the Commission issued Dec. 8, 2003), *available at* http://www.ftc.gov/os/adjpro/d9297/031218commissionopinion.pdf; *vacated, Schering-Plough v. FTC*, 2005 WL 528439 (11th Cir. 2005).

settlements. Not surprisingly, the Commission recently requested *en banc* rehearing.[16]

I am new to the Commission. I was not around when we brought the *Schering* case, when the ALJ ruled against the Agency, or when the Commission reversed on appeal. Still, I hope that the full 11th Circuit will hear the case and uphold the Commission's conclusion that these particular patent settlements harmed consumers. Experience tells us that negotiations between a brand and a generic over an entry date often lead to anticompetitive results – because brands can lose less and generics can earn more through exclusion payments that delay generic entry. Experience also tells us – both from the Generic Drug Study and our recent review of 22 settlement agreements (none of which had payments) provided to us under the 2003 Medicare Amendments' notification provisions – that brands do not need to pay generics to settle patent cases.[17]

Senator Orrin Hatch himself spoke to this issue in 2002 describing "collusive" agreements like *Schering* as "appalling" and adding from his perspective, as a drafter of Hatch-Waxman, that "[w]e did not wish to encourage situations where payments were made to generic firms not to sell generic drugs . . .".[18] Such concerns formed the genesis of the 2003 Medicare Amendments requiring notification, which resulted from an amendment proposed by Senators Patrick Leahy and Chuck Grassley. Clearly Congress was concerned about these agreements. If the 11th Circuit approach is adopted more broadly, my sense is that many in Congress will take notice. As well they should.

One last point on *Schering* that goes well beyond the Commission: the 11th Circuit opinion departed from long-standing precedent on the application of the "substantial evidence standard" for agency decision-making. Indeed, the opinion appears to treat the administrative law judge ("ALJ"), rather than the Commission, which has *de novo* fact finding authority, as the ultimate fact finder. That is wrong as a matter of law, and seemingly in conflict with the Supreme Court in *Universal Camera*, which states that the substantial evidence standard "is not modified in any way when the [agency] and its [ALJ] disagree."[19] If the 11th Circuit's application of that standard remains, it could have significant repercussions for many agencies

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[16] Petition of Respondent Federal Trade Commission for Rehearing En Banc (filed April 21, 2005), *available at* www.ftc.gov/os/2005/04/050421ftcpetrehearenbanc.pdf.

[17] Summary of Agreements Filed in FY 2004: A Report by the Bureau of Competition (released January 7, 2005), *available at* www.ftc.gov/os/2005/01/050107medicareactrpt.pdf

[18] Senate Floor Debates on S. 812 (statement of Sen. Orrin Hatch) (2002), *available at* http://hatch.senate.gov/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=551&Month=7&Year=2002.

[19] *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 496 (1951).

beyond the Commission. This is one reason – in addition, to the merits – why the Supreme Court is likely to take *cert* if we lose *en banc* in the 11th Circuit. If we do lose on rehearing, I will certainly urge the Commission to seek *cert.*

IV. Future Issues in Health Care

A. The Pharmaceutical Industry

Let's discuss a couple items that the Commission might want add to its health care agenda. First, we seem to have a bit of a "whack-a-mole"[20] problem with the pharmaceutical industry – as soon as we address one competitive problem, yet another related issue pops up that we need to whack back down. For example, the brand-generic settlement agreements were followed by the Orange Book listing cases. The Orange Book listing cases were followed by *Perrigo/Alpharma*,[21] in which two generic companies reached an agreement not to compete – in this instance for over-the-counter children's ibuprofen. We obtained a consent and disgorgement in that case, and we'll have to see whether these generic-generic agreements are a new trend that needs further examination from the Commission.

Another issue that has emerged – and that also deserves the Commission's attention – is authorized generics. For those of you not familiar with this term, it is a practice whereby a brand company introduces its own generic product, either right before or at the exact same time the first generic enters the market. Prior to 2003 there were only a handful of examples of this practice. But the use of this strategy by brand firms has increased substantially over the past couple years, with about two dozen instances since just the beginning of 2003. According to two recent reports by independent analysts, authorized generics are not, as Cole Porter might say, "a passing fa[ncy]" but are "here to stay."[22]

Are authorized generics a problem – or a red herring? On the one hand, authorized generics should provide short-term benefits to competition during the initial 180-day generic exclusivity period. Absent the authorized generic only one generic company gets that exclusivity period as a reward for filing the first application with the FDA. It most often has the 180-day period to itself. Consumers already benefit substantially during that period, as the generic usually undercuts the brand price by somewhere between 25 to 35 percent. Under the scenario

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[20] Carnival game which involves quickly and repeatedly hitting the heads of mechanical moles with a mallet as they pop up from their holes.

[21] *Perrigo Company and Alpharma Inc.*, Civil Action No. 1:04CV01397 (RMC) (D.D.C.) (complaint filed August 17, 2004), *available at* www.ftc.gov/os/caselist/0210197.htm.

[22] Prudential Equity Group, LLC, *Authorized Generics: Looks Like They're Here to Stay* (March 3, 2005), at 1; Morgan Stanley, *Quantifying the Impact from Authorized Generics* (December 9, 2004), at 1.

where the brand introduces its own low priced product during the 180-day period, we now have two generics competiting rather than one. Prices for the generic products should fall even greater – perhaps to around a 50 percent discount off the brand. That is good for consumers in the short-term.

On the other hand, the long-term implications are potentially troubling. The introduction of an authorized generic will likely diminish the incentives for generic firms to challenge patents and incur substantial development and litigation costs. And, of course, one of the reasons for a brand foregoing short-term profits on one product may be to chill the incentives of generics to develop competing products in the future.

My sense is that the impact on generic firms' incentives will vary. It is quite possible that for blockbuster drugs, the pot of gold for generics will still be large enough so that they will fight to be first to file and first to market. But we could very well see fewer generic applications for smaller drugs – the ones that won't earn several hundred million dollars a year in revenues. This could lead to fewer generic products on the market, which could then result in less competition down the road. That would be bad for consumers.

Several generic companies have argued that authorized generics are impermissible under Hatch-Waxman and violate the antitrust laws. I am not persuaded by these arguments. But I am persuaded that authorized generics may have competitive implications that could upset the Hatch-Waxman balance.

Don't just take my word for it, though, ask the Chairman of the Senate Finance Committee, Chuck Grassley, and the Ranking Democrat on the Judiciary Committee, Patrick Leahy. Along with Senator Rockefeller, they just sent a letter to the Commission noting concerns they have heard that authorized generics "could have a negative impact on competition" and drug prices, and asking that the Commission conduct a study of the competitive implications of authorized generics under our 6(b) authority. I think we would be wise to take this request seriously.[23]

Conducting such a study, requiring us to balance the effects of short-term benefits against long-term disincentives, will not be easy. But questions without easy answers – like this one – are exactly what President Wilson and Commissioner William J. Harris were thinking of at the inception of the Commission. The Commission, with its policy role, is perfectly suited to, in the words of Commissioner Harris, "give the Government and the public a correct knowledge of the facts . . .".

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[23] Letter from Senators Patrick Leahy, Chuck Grassley, and John Rockefeller to Chairman Deborah Platt Majoras (dated May 9, 2005).

B. Physician Price-Fixing Consents

The Commission has long been active in challenging physician pricing-fixing. Former Chairman Muris addressed this conduct in a 2002 health care speech whose title sums it up – "Everything Old is New Again"[24] – and noted that we have been bringing physician price-fixing cases for more than twenty years. Under Tim's tenure, from 2001 to 2004, the Commission brought nearly twenty cases, including recent consents that seemed to present more complicated issues involving messenger models, clinical integration, and financial risk-sharing. However, upon closer examination, most of these cases proved to be plain old-fashioned price-fixing.

The justification provided by some doctors for these arrangements is that insurers wield tremendous purchasing power, and thus physicians must be able to band together to fight off reduced reimbursement rates. To be sure, many doctors do face this problem. However, when we see conduct involving price-fixing or concerted refusals to deal – whether by physicians or anyone else – such violations almost certainly harm consumers.

In the spirit of "Everything Old is New Again," we do have to ask ourselves whether our method of pursuing physician price-fixing is also getting old at this point. Long after the Commission started bringing these cases, they still seem to be popping up every month or two. In Alamogordo, New Mexico; Seneca, South Carolina; Fort Worth, Texas and many other places, our staff has expended significant efforts to get the word out that this conduct runs afoul of the antitrust laws. Despite these efforts, many doctors don't seem to be getting the message. Sadly, they are often influenced by dubious consultants offering spurious advice.

In our consumer protection efforts, we constantly caution people about offers that look too good to be true. We should also caution physicians to be wary of similarly incredible offers – claiming you can jointly negotiate with a competitor, get fabulous reimbursement rates, and not run afoul of the antitrust laws. It is the equivalent of saying, "take this pill and even without diet or exercise, you can lose ten pounds overnight." You do not have to be an FTC Commissioner to know that this won't work. Get a second opinion.

Of course, we are serious about evaluating the efficiencies that can result from a messenger model, clinical integration, or financial risk-sharing – when the procompetitive benefits outweigh the anticompetitive effects. The problem is that you can't just slap the labels "messenger model" or "risk-sharing" on a price-fixing arrangement and use them as a "get out of jail free" card for price-fixing.

To better deter physician price-fixing, we also can learn a lot from our consumer

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[24] Timothy J. Muris, Chairman, Federal Trade Commission, *Everything Old is New Again: Health Care and Competition in the 21st Century*, remarks before 7th Annual Competition in Health Care Forum, Chicago, IL (November 7, 2002), at 16-18, *available at* www.ftc.gov/speeches/muris/murishealthcarespeech0211.pdf.

protection staff and perhaps borrow some of their tools. For example, our Consumer Protection Bureau often does "sweeps," where we investigate an industry and then, when we find multiple instances of unlawful conduct, package the cases together.

The benefit of a sweep is that it draws greater attention from the public, trade press, and practitioners in the relevant area. In the physician price-fixing arena, it could also serve as an educational tool that will hopefully raise red flags with doctors considering questionable conduct, providing a more effective deterrent than individual consents. Our Health Care Division is continuing to look at doctors' groups: you may see a sweep at some point down the road.

Another approach that could result in greater deterrence – which is not entirely new to our physician cases – is naming names. Our current consent orders generally bar the parties from engaging in similar conduct in the future, and impose some reporting and notice requirements. Many of those orders do not name the individuals, but simply constrain the activities of the entities involved.

In future cases, we should be aggressive in identifying ring leaders and, where we find them, we should name them. This includes doctors and their consultants – both lawyers and non-lawyers – who propose models to physicians which simply dress up price-fixing as something else. If individuals face a greater risk that they may be named – and that adverse publicity is likely to follow – they will be less likely to undertake such conduct. We have named individuals in the past, including physicians in *Piedmont Health Alliance*[25] and an agent in *Physicians Integrated Services of Denver*.[26] Sadly, we probably need to do this more often.

I hope that through a combination of these ideas, we will see a reduction in doctors fixing prices. If they do not work, though, we should probably consider stronger measures: disgorgement in appropriate cases and, for a real deterrent, civil fines for antitrust violations. The latter would require, however, Congress to change our statutory authority.

C. Non-profit Exemption

Let me touch on one final issue: the non-profit exemption to the FTC Act. The FTC Act gives the Commission authority over "persons, partnerships, or corporations." The definition of "corporation," however, has been interpreted in a manner that exempts non-profit entities. This has placed some disturbing constraints on the Commission's enforcement efforts.

The Commission has been able to assert jurisdiction – and the courts have accepted our

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[25] *Piedmont Health Alliance*, C-4106 (consent order issued January 29, 2004), *available at* www.ftc.gov/opa/2004/08/piedmont.htm.

[26] *Physicians Integrated Services of Denver, Inc.*, C-4054 (consent order issued July 16, 2002), *available at* www.ftc.gov/os/caselist/0110173.htm.

position – over entities that do not seek profit for themselves but whose activities provide financial benefit to members (*e.g.*, American Medical Association, California Dental Association). However, non-profit entities whose members do not engage in such activities have been deemed to fall outside the Commission's jurisdiction. Thus, in some instances, we have not gone after non-profits that we believed were culpable.

In other instances, we have had to take additional steps. For example, in the Commission's 2003 price-fixing consent involving *Maine Health Alliance*, we were able to obtain relief against the Alliance itself – a non-profit with for-profit physician members.[27] However, we were unable to challenge the hospital members of the Alliance with price-fixing because of their non-profit status. Only through the cooperation of the State of Maine – a partner in our investigation, which is not restricted under its statute from actions against non-profits – did we obtain relief against the hospitals.

When we first looked at the origins of this exemption, it seemed as mysterious as the meaning of the giant man restraining the giant horse at the entrance to our headquarters. But we recently learned it is a holdover from the Commission's predecessor, the Bureau of Corporations, and harkens back to a time when people thought non-profits were incapable of violating the laws. It is clear from many cases, however, that non-profits are occasionally capable of doing so.

In the future, as we investigate matters in the health care industry, the non-profit exemption will likely prove to be a continuing burden – and an unnecessary one. This exemption may prevent us from obtaining relief in future price-fixing investigations, or in other cases where non-profits seek to prevent entry by competitors. The exemption also may necessitate that we seek the assistance of DOJ or the States – as we did in *Maine Health Alliance* – to obtain relief. That most States and DOJ do not have this non-profit exemption clearly points out that it is an anomaly in the law.

Removing the non-profit exemption would require amending the FTC Act. This could be pursued directly by seeking legislative change, perhaps in conjunction with a recommendation from the Antitrust Modernization Commission. Because both the States and DOJ are not restricted in this manner, it's not clear whether non-profits would really put up much opposition. But if we pursue this course of action, I guess we'll find out.

V. Conclusion

In my next six years on the Commission, I expect there will be many plot twists and turns in the field of health care; some nefarious characters and, perhaps, a few heroes; maybe even a good chase scene or two. If you'll indulge another reference to my previous vocation, and my continuing avocation, I can imagine the kinds of blockbusters I'd like to help produce:

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[27] *The Maine Health Alliance*, C-4095 (consent order issued August 27, 2003), *available at* www.ftc.gov/opa/2003/07/maine.htm.

"Dangerous Liaisons," the remake, or "The Year of Colluding Dangerously." I am, at best, a supporting actor in this enterprise. But in the years to come, to borrow some titles of recent Academy Award nominees, I will do my best to make sure that the agency's efforts in this area – as a matter of both enforcement and policy – aren't "Lost in Translation." And I will work to see that there is fairness to all but aggressive pursuit of those bad actors in the health care field whose attitude amounts to "Catch Me if You Can."

Thank you.